Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL EQUIPMENT DEVICE SPECIALISTS
7950 DUNBROOK RD
SAN DIEGO CA 92126

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-4148-01

MFDR Date Received

JULY 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Specifically, in January 2011, we received bulk denials on every Liberty Mutual patient of our which contains the same exact denials. The denial code is xe20, a homegrown code from Liberty Mutual, which contains three different denial reasons. Since there was no indication which of the three was the actual reason for the denial, we have spent months inquiring in order to ascertain the specific reason, so that we may properly appeal, and/or make sure that the proper statute was satisfied in accordance with the denial by the carrier. (i.e. if there was a denial for medical necessity that a proper peer review was done so that we could file for an IRO.) Liberty Mutual has failed to respond as to why every patient falls under xe20, and failed to identify which of the tree denial reasons was the applicable one for each respective patient that was denied."

Amount in Dispute: $1,319.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DME charges in dispute were denied because they are outside of the ODG and required preauthorization was not requested. Rule 137.100(d) related to a carriers responsibility for reimbursement of treatments or services outside the ODG… The services being disputed were not 'provided in a medical emergency' and were not 'preauthorized in accordance with 134.600 or 137.300 of this title' therefore, our denial is appropriate… Our position remains unchanged regarding denial of the services in question."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2010 October 7, 2010 November 7, 2010 December 7, 2010 January 7, 2011	HCPCS Codes E1399, A4595	$778.00	$0.00

September 3, 2010	HCPCS Code A4595	$72.00	$0.00
December 12, 2010 February 7, 2011	HCPCS Codes E0731 and A4595	$469.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.20 Medical Bill Submission by Health Care Provider.
4. 28 Texas Administrative Code §133.250 Reconsideration for Payment of Medical Bills.
5. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
6. 28 Texas Administrative Code §137.100 sets out the procedures for health care under the treatment guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 55, X059 – Payment is not recommended for charges related to research, experimental or investigative services, and or drugs or treatment which has not been approved by the Division of Workers' Compensation or authorized by the carrier. For Texas jurisdiction claims only, per Texas Labor Code Section 413.031 and 28 Tex. Admin. Code Sections 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC-Appointed Independent Review Organization…
   - 50, X484 – According to the Texas Division of Workers Compensation's rules effective May 1, 2007, all medical treatment provided to workers compensation patients in the state of Texas must follow the official disability guidelines (ODG). The services provided are outside the ODG guidelines and no pre authorization was requested.
   - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
   - B14, XE20 – These services were delivered for a non-authorized DME device. The DME provider failed to obtain pre-authorization or the DME device was deemed in appropriate for the work related injury, by extension all related supplies lack the requisite authorization as well and are not separately reimbursable.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.307?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?

Findings

1. Date of service September 12, 2010 shows an amount in dispute of $0.00; therefore, this date of service will not be reviewed.
2. 28 Texas Administrative Code §133.307(c)(2)(A) and (B) requires that the requestor submit a copy of all medical bills, in paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills) and (B) a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. Review of the documentation for date of service **September 3, 2010** does not include a bill or EOB. The requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(A-B); therefore the amount ordered is $0.00.
3. 28 Texas Administrative Code §133.307(c)(2)(B) requires that the requestor submit a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. Review of the submitted documentation for dates of service **December 12, 2010** and **February 7, 2011** shows no EOBs were submitted for these dates of service; nor has the requestor supported that they billed the services in

dispute in accordance with 28 Texas Administrative Code §133.20 – Medical Bill Submission by Health Care Provider or §133.250 – Reconsideration for Payment of Medical Bills. The requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(B); therefore the amount ordered is $0.00.

4. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

   In accordance with 28 Texas Administrative Code §137.100 The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless: (1) the treatment(s) or service(s) were provided in a medical emergency; or (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title. Review of the submitted documentation finds that the insurance carrier denied the services per the Official Disability Guidelines. According to subparagraph (e) an insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonable required. According to 28 Texas Administrative Code §137.100(f) states that a health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title. Review of the documentation submitted by the requestor did not support the services rendered complied with the Official Disability Guidelines and confirms that preauthorization was not requested for the services billed. Documentation was not submitted for dates of service **September 2, 2010, September 12, 2010, October 7, 2010, November 7, 2010, November 7, 2010 and January 7, 2011** to support that the issues of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

5. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services nor has the requestor adhered to the rules of medical dispute resolution of fee disputes; medical bill submission by the health care provider and reconsideration of payment of medical bills. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 15, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.